Guideline

Department of Health, NSW
73 Miller Street North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Telephone (02) 9391 9000 Fax (02) 9391 9101
http://www.health.nsw.gov.au/policies/

Drug and Alcohol Clinical Supervision Guidelines

Document Number GL2006_009

Publication date 07-Jun-2006

Functional Sub group Clinical/ Patient Services - Medical Treatment
Clinical/ Patient Services - Nursing and Midwifery
Personnel/Workforce - Learning and Development

Summary This document provides comprehensive guidance in relation to the implementation of clinical supervision programs within NSW Drug and Alcohol (D&A) services. It informs local policies and provides a framework for good practice that D&A services can refer to.

Author Branch Centre for Drug and Alcohol

Branch contact Doug Smyth 9424 5804

Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation

Audience Clinical staff in Drug and Alcohol

Distributed to Public Health System, Community Health Centres, Divisions of General Practice, NSW Department of Health, Public Hospitals

Review date 07-Jun-2011

File No. 04/994-03

Status Active

Director-General

NSW HEALTH

NSW Drug and Alcohol Clinical Supervision Guidelines

NSW DEPARTMENT OF HEALTH
73 Miller Street
NORTH SYDNEY NSW 2060
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 9391 9900
www.health.nsw.gov.au

SHPN (D&A) 060037
ISBN 0 7347 3917 6

For more copies contact:
Better Health Centre – Publications Warehouse
Locked Mail Bag 5003
Gladesville NSW 2111
Tel. (02) 9816 0452
Fax. (02) 9816 0492

Further copies of this document can be downloaded from the
NSW Health website www.health.nsw.gov.au

April 2006

Contents

Executive summary 1

This document provides comprehensive guidance in relation to the implementation of clinical supervision programs within NSW Drug and Alcohol (D&A) services. In summary, the key messages contained within the Guidelines are:

- *Participation in clinical supervision is expected* of all staff in D&A services who provide direct services to clients, including medical and nursing staff, psychologists, social workers, D&A workers and D&A counsellors.
- It is advisable for D&A services to clearly articulate their requirements, arrangements and expectations in relation to clinical supervision in policies and procedures and to make staff aware of these.
- Managers and clinical leaders can play an important role in *engendering a culture of support and acceptance* for clinical supervision within the organisation.
- The *purpose of clinical supervision* is to provide a tool for workforce development, a mechanism for quality assurance and clinical safety, and a means of providing professional support and debriefing to staff.
- Clinical supervision sessions involve the *review and discussion of a worker's clinical practice* with a clinical supervisor. The content of such discussions remains confidential, except in circumstances of serious concern related to the ethical or professional conduct of the worker, or the safety of a worker or client.
- *Clinical supervision is not line management* and the two processes ought to remain separate. It is generally inadvisable for line managers to act as clinical supervisors for their direct reports. However it should be noted that this might not apply in medical settings where traditionally the Clinical Medical Director provides both clinical supervision and line management to junior medical colleagues.
- Supervisors, supervisees and managers all have *specific roles and responsibilities* within the clinical supervision process, and all parties need to be clear about these. Ideally, roles and responsibilities will be articulated in contractual arrangements or service agreements.
- Organisations can elect to utilise clinical supervisors who are either *internal (employed by the organisation) or external*. Both models are in operation and have merit.
- Clinical supervision can be offered as either *individual (one supervisor with one worker)* or group (one supervisor to a small number of staff). Both models are in operation and have merit, although there are particular issues that need to be taken into account in group supervision models.
- Supervisors need to be *trained in clinical supervision*, ensure that they operate within relevant ethical and professional codes of conduct, and provide supervision in line with the requirements of the service. Ideally, they will also access supervision for their clinical supervision practice.
- Clinical supervisors should be appointed through *appropriate recruitment and selection* processes and there are generally agreed criteria applicable to the selection of appropriate supervisors.
- Effective clinical supervision relies on the development of a strong *alliance between supervisors and supervisees*, and ideally there should be a degree of choice for workers in selection of a supervisor.
- Clinical supervision *programs need to remain flexible* to ensure that they meet the needs of workers at all stages of their development and career path.
- It is important for policies and procedures to spell out the appropriate mechanisms whereby staff, managers and supervisors can *address any concerns they have about clinical supervision*.
- Organisations need to ensure they put in place *appropriate infrastructure* to support, coordinate and manage clinical supervision programs.
- *Monitoring and evaluation* of clinical supervision programs is considered important to ensure that they are meeting objectives, to identify the benefits, determine effectiveness and levels of staff satisfaction, and to report on uptake and compliance across the organisation. Any such mechanisms should ensure that the content of clinical supervision sessions remains appropriately confidential.

All of the above issues are discussed comprehensively within the Guidelines.

Introduction and background 2

These Guidelines have been developed for the NSW Health Drug and Alcohol sector. This section outlines the impetus for and process of their development, their intended application and the policy context within which they operate.

2.1 Impetus for the guidelines

A number of key factors created the impetus for the NSW Drug and Alcohol Council to commission the development of NSW D&A Clinical Supervision Guidelines. Considerations were:

- A growing recognition of the value and importance of clinical supervision, and a desire to provide support to its broader implementation.
- Some concerns that the extent to which workers in D&A services were able to access clinical supervision was somewhat ad-hoc across the state.
- The need for a greater level of understanding about the purpose and benefits of clinical supervision.
- A desire to develop greater consistency in the implementation of clinical supervision programs within D&A services.

2.2 Policy context

The broad policy context within which the Guidelines sit is twofold. Firstly the NSW D&A Policy context, which is outlined in the *NSW Drug Treatment Services Plan 2000-2005* and which states that:

> *Clinical treatment should reflect good practice identified in the current research literature and documented in clinical outcome studies. Programs need to be flexible, individualised and based on the best available evidence of effectiveness'.*[1]

Clinical supervision provides one mechanism whereby services can facilitate 'good practice' on the part of individual clinicians, because through supervision, clinical practice is subject to a process of professional enquiry that aims to ensure that services to clients remain within treatment modalities that are known to be the most effective.

The second important policy context is that of clinical governance, which places responsibility for the quality of care jointly on organisations and individuals. Clinical governance is defined as:

> *The framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.*[2]

Ensuring the ongoing clinical competence of individual clinicians is a cornerstone of clinical governance, and this is formalised in NSW Health's *Framework for Managing the Quality of Health Services in NSW* and the supporting document The Clinician's Toolkit, which identifies the need for transparent and accountable processes to be in place, including clinical supervision for all clinicians. Clinical supervision is one of a number of activities that are designed to manage, enhance and monitor the delivery of clinical services, and active participation in clinical supervision is one way in which clinicians can exercise their individual responsibilities for clinical governance.[3]

In addition to the broad policy context described above, the majority of NSW Health D&A services already provide a level of clinical supervision for staff, and this is generally governed by local policies and procedures. As its name suggests, this document provides guidance, is not a policy, and is not intended to replace or take precedence over local policies and procedures, but rather to further inform local policies, and provide a framework for good practice that D&A services can refer to.

1 NSW Health Drug Treatment Services Plan 2000-2005.

2 NHS 1998, The new NHS: Modern and Dependable, quoted in NSW Health's The Clinicians Toolkit for Improving Patient Care, 2001.

3 Clinical Governance and Clinical Supervision; working together to ensure safe and accountable practice; A Briefing Paper. Butterworth and Woods, The School of Nursing, Midwifery and Health Visiting, University of Manchester 1999.

2.3 Intended application

The Guidelines are generic and intended to be applicable across disciplines to all workers in D&A services who have responsibility for the provision of direct services to clients, either individually or in groups. This includes medical staff, nursing staff, psychologists and social workers, as well as positions that are classified more generally as either D&A worker, or counsellor. At the outset, some comments related to scope and limitations of their application are warranted:

- The Guidelines are unlikely to be entirely appropriate for Aboriginal and Torres Strait Islander workers in D&A services. The scope of their development did not allow for extensive consultation and consideration of issues related to Indigenous staff; however, the indications are that Aboriginal and Torres Strait Islander workers may well have a particular need for clinical supervision given the complexities of their role, and because the potential for personal impact is g reater, due to their dual responsibilities to organisation and community. Whilst these Guidelines provide a basis for good practice, they would require further review and adjustment to be appropriate. Any such review should occur in collaboration, for example with the NSW Health Aboriginal Workforce Development Branch.
- As indicated above, the Guidelines are intended to apply to medical staff working within D&A services. However, it is acknowledged that health services have historically experienced a level of difficulty in engaging all medical staff in the full range of quality assurance mechanisms expected of them. It is therefore worth noting at the outset that it is the intention that the Guidelines apply to medical staff and to stress the importance of services developing agreed pathways for clinical supervision for this key professional group.
- There are specific requirements for clinical supervision associated with some professions, for example the requirements for psychologists seeking registration. These Guidelines are not intended to replace any such requirements, which clearly need to be adhered to as required, and negotiated on a case-by-case basis between workers and services.
- The Guidelines are applicable to staff employed within D&A services, and are not intended to apply to students on placement who are not employees. Whilst students may well have clinical and/or other supervision requirements associated with their placement, these are not referred to in this document.
- The intent of the Guidelines is to allow for flexibility. They are not prescriptive, but rather make suggestions about what constitutes good practice. Whilst the evidence related to clinical supervision is somewhat limited, there are themes in the literature about what is commonly considered to be sound or best practice, much of which is already reflected in some D&A clinical supervision programs. There is no single recommended model of clinical supervision, and there is a need for services to have flexibility to implement programs and processes appropriate to the local context, and within the available resources. The Guidelines are intended to provide a framework for, and support to local operations, and to encourage a degree of consistency across the state. In addition, the recent amalgamation of Area Health Services (AHSs) will potentially require the review of two existing approaches to clinical supervision and agreement about one Area-wide approach. It is anticipated that this document may assist with any such deliberations.

2.4 Development process

In June 2005 the CDA contracted an external consultant (Jacq Hackett Consulting) to develop the Guidelines and established an Advisory Group to provide oversight to the process. Membership of the Advisory Group is at Appendix 1. During the same timeframe, a related consultancy was commissioned for the development and delivery of *Clinical Supervision Training* for senior clinicians within NSW Health Drug and Alcohol Services. This project was undertaken by Access Macquarie Ltd, and work undertaken through this project also informed the development of the Guidelines.

Key steps in the development process were as follows:

- A review of current processes and policies for clinical supervision within D&A Services across the state.
- Broad consultation with stakeholders from AHSs[4] including D&A Directors, Service Managers, clinicians,

4 Site visits were held in SSWAHS (Croydon), H&NEAHS (Tamworth and Newcastle sites) and SWAHS (Parramatta, Penrith and Blue Mountains), GWAHS (Dubbo), NCAHS (Lismore, and telephone consultations in Coffs Harbour).

D&A workers, MERIT staff and internal and external providers of clinical supervision. In addition interviews were undertaken with staff from Justice Health, Odyssey House, NADA (Network of Alcohol and Drug Agencies), the CDA, the Centre for Aboriginal Health, Aboriginal Workforce Development Branch, NCETA (National Centre for Education and Training on Addiction), Relationships Australia and with the co-chairs of the D&A Nursing Advisory Committee and the D&A Allied Health Workers Advisory Committee.

- Review of findings from work undertaken by Access Macquarie Ltd as part of their training needs analysis, including an email survey of NSW D&A workers and a series of consultations with Aboriginal and Torres Strait Islander D&A workers.
- A desktop review of relevant documentation and literature.
- The development of a Discussion Paper that was distributed to all D&A Directors for comment and feedback.
- The development of Draft Guidelines, taking account of feedback from the Discussion Paper, also distributed to D&A Directors for comment and feedback.
- The development of Final Guidelines incorporating feedback on the Draft.
- Close collaboration and consultation with the Advisory Group at all key stages of the project.

Definition and purpose of Clinical Supervision

3

This section provides a working definition of clinical supervision as it applies throughout these Guidelines. It also outlines the common benefits of clinical supervision from the perspective of organisations and staff.

3.1 What is Clinical Supervision?

Agreeing a definition is never easy, and indeed the literature offers an extensive range of definitions for the term clinical supervision. In addition, the views of workers in the field about the meaning of clinical supervision are somewhat variable. However, there are some common themes, and three key purposes for clinical supervision emerge, it is a:

- Tool for workforce development – that is, through discussion of research findings and reflection on current practices, it provides an opportunity for the development of the worker's professional identity, skills and knowledge, and awareness of the impact of personal attitudes and issues on clients
- Mechanism for quality assurance and clinical safety – that is, it is part of a suite of activities designed to ensure that services to clients are appropriate, safe and effective, and to identify and address any concerns or breaches in a constructive manner, in an appropriately formal, but confidential setting.
- Means of providing professional support and debriefing – workers reportedly benefit from a formal forum where they can debrief aspects of their work and gain support to manage any personal impact. This can become even more necessary in the Drug and Alcohol field where the work can be particularly complex and demanding.

There is no single definition of clinical supervision that is more correct than any other, and D&A service policies already include definitions that are considered appropriate for the local context. Nonetheless it is important to include a definition in these Guidelines in order to engender a shared sense of meaning.

For the purposes of these Guidelines, clinical supervision is defined as:

> *A formal and ongoing arrangement between one worker and a (generally) more experienced practitioner whereby the clinical practice of the worker is reviewed and discussed in confidence for the purposes of:*
>
> – *Further developing the worker's professional identity and clinical practice skills and knowledge.*
>
> – *Ensuring workers are operating within relevant clinical, organisational, ethical and professional boundaries.*
>
> – *Monitoring and supporting the worker's wellbeing and coping capacity in relation to their work.*

3.2 Benefits of Clinical Supervision

As discussed earlier, the evidence based knowledge about the benefits of clinical supervision is somewhat limited, and comprehensive, reliable evaluation studies have yet to be undertaken in the field. Notwithstanding these limitations, the available evidence does suggest that clinical supervision:

- Is commonly valued by managers and practitioners.
- Can facilitate the acquisition of complex clinical skills.
- Is associated with higher levels of job satisfaction or morale, where it is perceived to be of high quality.
- Can support staff retention.

There is a wealth of anecdotal knowledge and theorising in the literature and resources pertaining to clinical supervision, and findings from these, and from the consultations held within NSW commonly suggest that the following benefits are likely:

For the organisation/service:

- It contributes to workforce development.
- It contributes to quality assurance and to maintaining clinical safety.

- It provides a mechanism for ensuring that professional boundaries and codes of ethics are being complied with in the delivery of services to clients.
- It ensures that individual workers are operating within agreed treatment modalities.
- It provides a level of assurance that new or inexperienced workers are receiving appropriate support, learning and guidance in developing their role.
- It provides a level of assurance that more experienced staff are being exposed to new ideas, reflecting on their current practices, and where appropriate, are being challenged and stretched in relation to their clinical practice.

For workers receiving clinical supervision:

- It provides a mechanism for support and debrief, and for managing workplace stress.
- It provides an opportunity for coaching and professional guidance, for enhancing skills, identifying new ways of working with clients, and identifying areas of further skill development.
- It provides a confidential mechanism through which they can reflect on and raise issues related to their practice.
- It can validate their work clinical skills and contribute to increasing confidence in their work with clients.
- It can prevent workers operating outside appropriate boundaries with clients.
- It can contribute to increased job satisfaction, reduced stress and prevention of burnout.

Key elements of Clinical Supervision 4

This section helps further clarify what we mean by clinical supervision by outlining its common characteristics, the key parties involved and the common structure and processes utilised in its implementation.

4.1 Common characteristics of Clinical Supervision

As outlined earlier, clinical supervision sits within an overall *framework of clinical governance* and as such, is one of a number of mechanisms that are put in place to facilitate clinical safety, and which workers are expected to participate in. Other examples include clinical case review meetings, clinical audits, mandatory training and critical incident debriefings. Whilst clinical supervision is not commonly mandated within NSW Health services[5], there is nonetheless an expectation that it will be organised and supported by management and that workers will participate.

Clinical supervision is a *formal organisational arrangement*, commonly governed by policies and/or procedures that set out its purpose, the administrative arrangements, and the expectations and responsibilities of the key parties. Whilst the content of clinical supervision sessions remains largely confidential, and can be tailored to the needs of individual workers, it is not a private arrangement. Rather, it is conducted as part and parcel of workplace activities, and in line with the needs and requirements of the organisation. As such, clinical supervision must reflect the goals of the organisation and support the agreed/endorsed organisational approaches and therapeutic modalities.

Clinical supervision sessions are formalised, have an agreed purpose, work towards outcomes and entail an element of rigour. It is expected that all three primary purposes of clinical supervision are addressed, namely issues relevant to clinical safety, skill and knowledge development, and support and debrief.

There are three parties involved in clinical supervision arrangements – the supervisee (worker), the supervisor and the organisation (manager). Whilst only the worker and supervisor actually participate in clinical supervision sessions, the organisation has a clear role in organising, managing and supporting the clinical supervision program. More information about the roles and responsibilities of the three parties can be found in section 5.

Clinical supervision is appropriate regardless of a staff member's level of experience or their professional background. All staff can benefit from clinical supervision and it is appropriate for services to expect participation from all workers that fall within the parameters of their local policy.

Clinical supervision needs to be flexible to ensure it meets the needs of workers at all stages of their development. The supervision requirements of a novice worker are likely to be very different from that of a highly experienced worker, and this requires flexibility within the clinical supervision program to ensure workers at all levels of experience benefit.

The primary focus is the clinical practice of the worker. Whilst discussion of clients and their case management is an integral part of the supervision process, this is principally for the purpose of providing a tool for reviewing and discussing the clinical practice of the supervisee. The focus remains on developing the worker's conceptualisations, skills and knowledge, rather than on providing indirect treatment of the client.

Effective clinical supervision relies on the development of a strong alliance between supervisors and supervisees. A successful alliance will involve the development of a bond between the two parties, the establishment of clear goals for the clinical supervision process, and an agreed set of tasks to achieve the goals.

Ideally, there will be an element of choice on the part of the supervisee in selecting an appropriate supervisor. Clearly, achieving a 'match' between supervisee and supervisor is an important factor in ensuring a strong supervisory alliance, and having the flexibility for some negotiation on the part of the supervisee is likely to assist in achieving this. Notwithstanding this ideal, it is acknowledged that this may not always be possible, and there is a need for services to remain pragmatic in relation to this issue.

The content of clinical supervision is confidential, except in circumstances of serious concern related to the ethical or professional conduct of the worker, or the safety of a

5 A small number of D&A service policies do state that participation in clinical supervision is mandatory for workers.

client. The intent is to allow for frank and open discussion about clinical practice, in a safe environment. Further discussion of confidentiality is discussed in section 6.

Clinical supervision is not line management and the two processes should remain separate. Whilst managers certainly have responsibilities in the clinical supervision program (see section 5.3), the purpose of clinical supervision is distinctly separate from that of line management supervision. Overall clinical accountability for services to clients is an organisational and line management responsibility, whereas clinical supervisors are responsible for addressing only those matters raised within clinical supervision sessions, and only within the agreed parameters outlined in the clinical supervision policy.

It is strongly recommended that line managers do not also provide clinical supervision to staff that report directly to them. Whilst it is acknowledged that there are exceptional circumstances where this cannot be avoided, it should be considered a last resort, and will require careful attention to clear boundaries to ensure an appropriate separation of the two roles, and a high degree of trust and mutual respect between the two parties.

4.2 Structure of Clinical Supervision sessions

What is outlined here are the *common* structures and processes involved in clinical supervision. These are not set in concrete, are offered as a guide, and there is scope for D&A services to have some flexibility around local arrangements.

Clinical supervision is organised as individual sessions or appointments, commonly of one hour's duration and held monthly. They involve a worker (or group of workers) and a supervisor working together in private and without interruption.

For novice workers or those with limited experience, a high degree of structure is common and the role of the supervisor tends to be somewhat directive, involving a high degree of guidance and modeling. For highly experienced workers, clinical supervision sessions are likely to have less need of such structure, and there is scope for more supervisee-led discussion and identification of relevant issues.

In newly establishing clinical supervision arrangements there is commonly a process at the outset whereby the goals of the supervisee are agreed, the boundaries of confidentiality are made clear, and there is discussion and agreement about how the two parties will work together. Commonly, such agreements are formalised in a written contract or agreement, and an example of a supervisor/supervisee agreement can be found at Appendix 3.

Clinical supervision sessions utilise a range of processes to achieve their agreed purpose. As outlined earlier, the focus of sessions is always on the role and clinical practice of the supervisee, and it is the responsibility of the supervisor to ensure that sessions are appropriately structured to engage the supervisee in discussion, reflection and appropriate disclosure. The most common method of generating discussion and identifying the pertinent issues is through *case presentation or review*, in which a worker presents a case they are currently working on, commonly utilising an agreed presentation format, and requiring a degree of preparation on the part of the supervisee prior to the clinical supervision session. Less common, but important processes used in clinical supervision sessions are direct supervisor observation of a worker with a client, video or audio recording of a client intervention, and review of case notes and documentation.

Regardless of what method is used, it is the intention of clinical supervision sessions to generate discussion and reflection on a broad range of issues directly related to clinical practice, including but not limited to:

- The methods and modalities of clinical practice.
- Concerns the worker has in relation to any aspect of a case or client.
- Difficulties or lack of progress with a client.
- Awareness of the potential impact of the worker's personal values on their clinical practice.
- Identifying any negative impact on the worker from a case they are managing.
- Issues related to establishing and maintaining appropriate boundaries with clients.
- Ethical and professional practice, and compliance with codes of conduct.
- Professional identity and role development.
- Skill and knowledge development.
- Issues related to workload management, team functioning and career development.

Roles and responsibilities 5

This section provides guidance about the roles and responsibilities of the three key parties involved in clinical supervision – supervisors, supervisees and managers. It also outlines the responsibilities of all three in upholding the ethical and professional codes of conduct that are applicable in the clinical supervision process.

5.1 Supervisors

The common responsibilities of supervisors are to:

- Ensure they are clear about the organisational goals, the supported treatment modalities of the D&A Service, and any relevant codes of conduct or ethical standards applicable to those they are supervising. Ensure that their supervision practice is in line with all of the above.
- Ensure that supervisees are clear at the outset about the purpose of supervision, what is expected of them, the role of the supervisor, the parameters of confidentiality, and the appropriate mechanisms for addressing any difficulties or concerns about the clinical supervision process.
- Work with supervisees to agree on goals for supervision sessions, and put in place processes for regular review of progress.
- Enter into any required formal contractual arrangements in relation to the provision of clinical supervision services, including with the organisation and with individual supervisees. Examples of contracts between services and supervisors can be found at Appendices 4 and 5.
- Facilitate a safe and trusting environment for clinical supervision sessions.
- Ensure that clinical supervision sessions have structure, and work toward achievements in all three of the purpose areas identified earlier. This will require the initiation of processes whereby the supervisee can review and reflect on their clinical practice, identify areas of concern, explore new ways of working, identify development needs, and debrief issues of concern.
- Validate good practice and provide constructive feedback where appropriate.
- Challenge practice that is inappropriate, or which does not fit with the agreed treatment modalities of the Service, and facilitate the development of sound clinical skills and ethical practice.
- Work within the agreed boundaries of confidentiality and take responsibility for reporting any serious issues to line managers, and for informing supervisees when such a circumstance arises.
- Share their own knowledge, experience and skills with supervisees.
- Take responsibility for ensuring they provide clinical supervision only within the limits of their expertise.
- Participate in any agreed monitoring or reporting mechanisms related to the provision of clinical supervision.
- Contribute to evaluation of clinical supervision programs as required by the D&A service.
- For externally contracted supervisors, where general concerns arise in relation their clinical supervision (that is, not concerns related to individual supervisees) take steps to address these issues with the appropriate manager, not with supervisees. Examples of such concerns include issues related to the agreed clinical modalities or work practices of the service, or the contractual arrangements. In the event that an external supervisor considers their own professional views are inconsistent with those of the organisation, or in the event of any conflict of interest, take appropriate steps to terminate the contract.

5.2 Supervisees

In reality, workers have a range of different values and attitudes towards the idea of clinical supervision, along the spectrum from positive to negative, often related to their professional background, or their previous experience of clinical supervision. This inevitably results in some workers being willing, responsive participants, and others being reluctant or even resistant. Notwithstanding this, participation in clinical supervision is expected of all workers in D&A services and they also have responsibilities related to this.

The common responsibilities of supervisees include:

- Negotiate arrangements for clinical supervision, in line with organisational polices or procedures, and with line management approval.
- Ensure regular attendance as agreed with the organisation, and in line with local policies
- Work with the supervisor to agree the goals of clinical supervision, and agree ways of working together.
- Undertake an appropriate level of preparation for clinical supervision sessions, for example preparation of case review material and completion of any agreed homework.
- Actively participate in all sessions.
- Take action in relation to any development needs identified through clinical supervision.
- Maintain any records related to clinical supervision sessions as set out in local policies or procedures.
- Resolve any difficulties or concerns with supervision through appropriate processes, for example in the first instance by discussing the matter with the supervisor, and if the matter remains unresolved, taking it up with the line manager and/or appropriate others within the service. In circumstances in which concerns have not been resolved through these processes, workers should refer to the applicable grievance or complaints procedure.
- Contribute to evaluation of clinical supervision programs as required by the D&A service.
- For group supervision, comply with the parameters of confidentiality that are agreed by the group.

5.3 Managers

Because clinical supervision is a formal organisational arrangement, managers play a key role in its implementation. The common responsibilities of managers include:

- Ensure staff are aware of the D&A service's policy and procedures related to clinical supervision, and the expectations of their participation.
- Ensure that all relevant staff can access clinical supervision. This includes making any changes in the workplace required to enable staff to attend, for example rostering arrangements, making transport available, establishing group supervision arrangements, making meeting rooms available etc.
- Where an external supervision model is in operation, recruit and arrange contracts with appropriate clinical supervisors and ensure attention to key issues such as insurance requirements and criminal record checks. Where internal supervision models operate, ensure compliance with any formal agreements.
- Ensure clinical supervisors are appropriately briefed. This will be particularly important for external supervisors to ensure they are oriented to the requirements of the D&A service, including the supported treatment modalities and any relevant codes of ethics or conduct. It may also be helpful for supervisors to be informed about any related policies and procedures, for example in relation to managing suicide risk, violent or intoxicated clients, guidelines for home visiting etc. Managers need to also keep supervisors informed of any changes in policies or treatment practices in a timely manner.
- Where an internal supervision model is in operation, ensure that staff are made aware of the processes for engaging a supervisor and undertake any necessary approval processes as prescribed in local policies/procedures.
- Take reasonable steps to ensure that workers have an element of choice in selection of a clinical supervisor.
- Comply with any organisational reporting requirements in relation to clinical supervision, for example reporting attendance numbers and frequency, and associated costs and resources.
- Participate in and/or take responsibility for regular review and evaluation of clinical supervision programs.
- Take reasonable steps to resolve any concerns raised by supervisees in relation to their clinical supervision.

5.4 Ethical guidelines and codes of conduct

Managers, supervisees and supervisors all need to be aware of their common responsibilities in ensuring compliance with relevant codes of conduct, ethics and professional practice. Clinical supervision is one mechanism through which breaches of such codes can be identified, and concerns about inappropriate practice can be identified and addressed early, potentially preventing future breaches. (For example addressing

the early signs of inappropriate boundaries with clients). What constitutes appropriate and sound clinical practice is outlined within a number of key documents, some of which apply to all workers, and some of which apply to workers within specific professions.

All workers must comply with the following:

- Mandatory reporting requirements under the *Children and Young Persons Care and Protection Act*, which requires them to report suspicion that a child is at risk of harm, as defined in the *Act* and which is clearly outlined in the *NSW Health Frontline Procedures for the Protection of Children and Young People*.
- The legal obligations outlined within the *NSW Policy for Identifying and Responding to Domestic Violence*; and which outline the obligations of AHSs to ensure appropriate response to individuals at risk of, or having experienced domestic violence across health settings.
- Their local Area Health Service *Code of Conduct*. Whilst there may be some variations in such Codes of Conduct, commonly they provide guidance about appropriate conduct in relation to conflicts of interest, the acceptance of gifts or benefits, bribery and corrupt conduct, the development of inappropriate personal relationships with clients (including social, sexual or financial relationships), acting with honesty and integrity, harassment and bullying and professional standards of behavior.

Supervisors need to be familiar with all of the above documents and have a sound understanding of compliance as it relates directly to the provision of services within the D&A setting. Managers need to ensure that supervisors are provided with copies of all relevant documents.

In addition to the above requirements, there are also specific professional and ethical codes that apply to some individual professions, and supervisors also need to be aware of which of these additional codes apply to their supervisees. In summary, these codes are:

- The NSW Medical Board Code of Professional Conduct.
- Code of Ethics for Nurses in Australia (Developed under the auspices of Australian Nursing and Midwifery Council, Royal College of Nursing, Australia, and the Australian Nursing Federation).
- Code of Professional Conduct for Nurses in Australia (Australian Nursing and Midwifery Council).
- Australian Association of Social Workers Code of Ethics.
- NSW Psychologists Registration Board Code of Professional Conduct.
- The Australian Psychological Society Code of Ethics.
- Australian Counselling Association Code of Conduct.

Further information related to ethical and professional codes of conduct, including web references to access the complete documents as listed above can be found at Appendix 2.

Supervisors also need to ensure that their own clinical supervision practices remain within ethical and professional parameters, and to ensure they take appropriate steps to protect themselves, the supervisee and the organisation, for example by ensuring that:

- Their clinical supervision practice remains within their level of competence and capabilities.
- They are appropriately trained to provide supervision.
- They operate with clear contractual arrangements in relation to their role and responsibilities with the organisation, and in relation to their work with supervisees.
- They operate within the agreed parameters of confidentiality.
- They do not develop inappropriate boundaries or relationships with supervisees.

Confidentiality 6

Issues related to the confidentiality of clinical supervision can be somewhat contentious. On the one hand there is a need to ensure the confidentiality of individual sessions in order to provide a safe and constructive learning environment, and to encourage a sufficient level of disclosure. On the other, given the role of clinical supervision as a mechanism for clinical quality and safety, there is a need to ensure that any sufficiently serious issues related to clinical practice are dealt with appropriately and transparently. To balance these two legitimate concerns, the parameters of confidentiality need to be clear, documented, and communicated to all participating parties.

These Guidelines propose that to ensure an appropriate measure of accountability for clinical supervision, confidentiality is ensured except in circumstances where there is:

- A breach of the code of conduct of the organisation.
- A breach of professional code of ethics.
- A breach of duty of care.
- Serious concern about the safety of the worker or a client.
- Issues identified that are subject to mandatory reporting requirements.

Adherence to these parameters requires that supervisors are sufficiently clear about the particular role of the worker, and are cognisant of the relevant codes of ethics, professional conduct, duty of care and mandatory reporting requirements.

In any of the circumstances outlined above, it is the responsibility of the clinical supervisor to inform the worker of their concerns and of the need to inform the line manager. Clinical supervisors need to take such concerns to managers as soon as is practical once they are identified.

Operational approaches to Clinical Supervision

7

This section of the Guidelines provides information about internal and external supervision approaches to clinical supervision, and about individual and group supervision approaches. All these approaches are appropriate and have merit, and D&A services commonly have to make decisions about which models to implement. The following information is intended to be of assistance to services in their decision-making, and to facilitate sound practice, whichever approach is in place.

7.1 Internal Clinical Supervision

In this approach to clinical supervision, supervisors are employees of the organisation, and take on clinical supervision as an adjunct to their primary role. This model is commonly selected by services because:

- The majority of resources required to provide clinical supervision can be found internally within the organisation, and therefore do not incur additional costs.
- It utilises and values existing expertise and experience.
- It can provide an opportunity for some staff to extend their role, skills and experience through taking on a clinical supervision role.
- There can be benefits where internal clinical supervisors have a greater understanding about the needs of the organisation, for example, the agreed treatment modalities, the working environment, and the specific complexities of the client group.
- It is often perceived to be more straightforward to organise and administer.

There are many different operational models of internal clinical supervision in place in D&A services, reportedly with varying degrees of success. Ideally, internal models of clinical supervision will take account of the following factors, which are considered to represent good or sound practice, and which will likely assist in ensuring the effectiveness of the clinical supervision program.[6]

Appropriate and transparent processes for recruitment and selection of clinical supervisors. Whilst more comprehensive guidance can be found in relation to this in section 8.2, it is important to stress that the need for such processes is a critical, yet sometimes overlooked factor in the implementation of programs that utilise internal supervisors. Whereas formal processes for recruitment and selection of external supervisions is common, they tend to be less rigorous for internal supervisors, and yet are equally important.

The provision of training for selected supervisors in the clinical supervision role. Ideally, the training will be conducted by an external individual or organisation with relevant expertise, with sufficient briefing about the particular organisational issues/requirements.

The use of contracts or service agreements to govern the clinical supervision work of staff that clearly outlines the expectations and parameters of the role. Again, this can tend to be overlooked when utilising internal clinical supervisors, when in fact, there is potentially a heightened need for transparency about the role, function and expectations.

The establishment of a pool of clinical supervisors from which workers can chose. Offering an element of choice on the part of the worker in selecting a clinical supervisor is always ideal; however, where internal clinical supervisors are utilised this becomes somewhat of an imperative. Internal supervisors inevitably have less objectivity than external supervisors, and the reality of organisations is that there is generally history and baggage between some staff. The literature confirms the importance of 'match' between supervisor and supervisee if the process is to be effective, and when using internal arrangements, choice is particularly important.

The establishment of protocols for reaching agreement between a worker and a clinical supervisor to work together. Workers require more than a list of names if they are to make an informed choice in relation to selecting a clinical supervisor. Clinical supervisors need to feel confident that they can work effectively

6 Some of the factors outlined are also applicable for external supervision models, and whilst efforts are made to minimise repetition in these Guidelines, some repetition is unavoidable.

with their supervisee, and also have an element of choice and decision-making. Suggested protocols include:

- Ready availability of relevant written information about the clinical supervisors in the organisational pool. For example information about their background, qualifications and experience, their particular strengths and areas of interest, and information about their preferred counselling or treatment modalities.
- A meeting to undertake a process of 'mutual interview' between worker and clinical supervisor to assess expectations and 'fit', prior to committing to any ongoing arrangements.
- Early review of the appropriateness of the arrangement and an understanding of 'no blame' or recourse if there is agreement to terminate.

The need to ensure that the supervisors fully understand the boundaries of confidentiality of clinical supervision sessions, and are provided with documentation that outlines the ethical and professional codes of conduct applicable to staff they will be supervising.

The establishment of mechanisms for accountability for internal clinical supervisors to ensure that their supervision practice remains sound over the longer term, and in line with the requirements of the organisation. Whilst section 8 provides further guidance about organisational issues, what is being stressed here is the need for mandatory participation on the part of internal clinical supervisors in a range of activities designed to bring a level of accountability to the clinical supervision program. For example participation in supervision of their clinical supervision work, preferably from an external practitioner, attendance at clinical supervision network meetings, participation in ongoing training and development opportunities.

The use of formal written agreements between internal supervisors and supervisees, for example to agree the goals of supervision, the frequency and duration, the agreed processes and ways of working together. This is considered particularly important for novice or inexperienced workers and supervisors.

Flexibility to ensure that highly experienced senior staff have access to appropriate clinical supervision, which may mean offering exemption from the internal model. It is well acknowledged in the literature that accessing appropriate clinical supervision is generally more difficult for those staff with extensive experience, or who are considered to be the most senior staff within a service. Ideally, clinical supervision is provided by a more senior practitioner, and this may only be possible by going externally. Alternatively, peer supervision may be an appropriate option, and this may also require flexibility for this to be sought externally.

7.2 External Clinical Supervision

In this approach supervisors are external to the organisation and are contracted to provide an agreed level of clinical supervision services. Commonly in D&A services external clinical supervisors are registered clinical psychologists, and are paid on an hourly basis in line with the standard professional rate. This model is commonly selected by services because:

- It provides an opportunity to recruit from a broader field and potentially a greater capacity to be selective.
- External people can bring external ideas, views and perspectives, which are potentially helpful to the organisation.
- Contractual arrangements are required, and so there is generally a greater acceptance that the role, responsibilities, reporting requirements and circumstances under which the services will be terminated can be clearly stipulated (than with internal arrangements).
- External supervisors are more likely to bring a lack of bias or subjectivity, which is beneficial to the supervision process.
- There is potential for a more open and honest supervisory process than with some internal arrangements because staff are more confident about the confidential nature of the relationship and do not have to interact with the supervisor in other settings.
- Internal staff time, training and support is not required (for supervisors).

Ideally, external models of clinical supervision will take account of the following factors:

Appropriate and transparent processes for recruitment and selection of clinical supervisors. (See section 8.2). In addition, recruitment processes will need to ensure that a criminal record check is undertaken.

The need to ensure that external clinical supervisors are fully cognisant of relevant organisational issues, for example:

- The goals, priorities and agreed treatment modalities.
- Organisational structure.
- The role and responsibilities of staff they will be supervising.
- Intake and assessment procedures.
- Weekly operational structure.

The need to ensure that external supervisors fully understand the boundaries of confidentiality of clinical supervision sessions, and are provided with documentation that outlines the ethical and professional codes of conduct applicable to staff they will be supervising.

Appropriate briefing and orientation of external supervisors by managers, and regular monitoring and review of services provided.

The selection of supervisors whose professional values are sufficiently congruent with those required by the organisation. In particular it will be important to select supervisors who are able to support harm minimisation approaches common to the provision of treatment services within the NSW Health D&A environment.

Contractual arrangements are put in place that clearly specify all aspects of the clinical supervision arrangement, for example the responsibilities of the clinical supervisor, requirements for any documentation related to clinical supervision sessions, payment, term of the contract, reporting requirements.

7.3 Individual and Group Supervision

Another key consideration for D&A services is whether to provide group or individual supervision. Both are common and have merit. As it implies, individual clinical supervision is a one-to-one process between a clinical supervisor and an individual worker. In group supervision a number of workers get together with one clinical supervisor. Many D&A services opt for a group supervision approach primarily because of its cost effectiveness, however there are other benefits, including:

- It can be a less threatening approach for some people compared to individual clinical supervision.
- It can contribute to team building and cohesiveness.
- It can draw on the expertise and knowledge of other group members, which can be extremely valuable.

Not surprisingly, individual clinical supervision tends to be the more straightforward approach, and does have some advantages over group supervision, for example:

- It involves building one trusting relationship.
- Confidentiality can be more easily guaranteed.
- Workers tend to have a greater level of self-disclosure that can lead to increased insight.
- There is more time available to focus on each individual worker.

The supervisory role is more easily managed with one supervisee.

There is a greater capacity to find a good match between supervisor and supervisee.

Notwithstanding the above, group supervision is a common approach within D&A services currently, and because it can be less straightforward, and there are additional factors that need to be considered, this section provides some guidance in relation to this.

Group clinical supervision (as defined within these Guidelines) involves a clinical supervisor. This may seem an obvious point to make, however, peer supervision in groups does occur in health settings, and these Guidelines seek to draw a distinction between that and the approach intended here, where there is a designated role of supervisor, with responsibilities as outlined earlier in section 5.1.

If group supervision is to be effective, clinical supervisors must have skills and experience in facilitating groups. Generally, clinical supervision training does not include training in group work, and such expertise is usually developed over time through hands on experience working with groups. In selecting supervisors for group supervision, group work skills and experience need to be added to the essential selection criteria.

As a general rule, small is better in terms of numbers. Given the purpose of clinical supervision (to develop skills and knowledge, provide professional support and facilitate sound clinical practice) it is clear that there are limitations to how effective a group setting can be in achieving this if the numbers are high. As a general rule, three or four is considered ideal.

It will be helpful to have more than one clinical supervisor operating group supervision within the organisation, thereby allowing workers some element of choice. The importance of match has been referred to previously, and the issue of choice is obviously more difficult to achieve with group supervision; however, limited choice is preferable to none.

It is important to pay attention to the membership mix when establishing group supervision arrangements. The sessions need to offer all members an opportunity for learning and growth, and provide a safe and trusting environment in which disclosure and honesty are the norm. To achieve this, it is important that some planning takes place at the outset, rather than having groups either selected at random or completely self selected. Useful considerations are having workers who are at a similar level of experience and skill, similar professional backgrounds, and avoiding situations in which there are power differentials between members, for example by including a worker and their team leader in the same group. Inevitably in organisations there are also situations where negative history between workers make it inappropriate to have them join the same group, and this may require some sensitive management.

Discipline specific and multidisciplinary groups can both be effective. There are mixed views in the field about this issue, and a tendency for some workers to believe that they should only be in groups with others from the same profession. However, there is no evidence to support this approach exclusively and both models are in use and can work well.

There are some inevitable limitations to group approaches to clinical supervision compared with individual supervision. They are outlined below not to promote one approach in favour of another, but rather to provide useful additional information for consideration in implementation. Common limitations are:

- Some people are not sufficiently comfortable in a group setting to openly discuss and explore issues related to their work practices, or to debrief difficult issues. Where this is the case, those workers can tend to be low contributors, or can be so uncomfortable as to have a generally negative experience of clinical supervision (which essentially renders it ineffective).
- It can be more difficult to address issues or problems related to team functioning, which is a legitimate issue that clinical supervision can be helpful in addressing. Without skilled facilitation there can be a tendency for sessions to become simply a forum for complaints.
- There are limitations in the extent to which workers are likely to disclose in relation to certain issues because they are with colleagues. In reality, group sessions cannot offer the same level of confidentiality as individual sessions, and this will impact on the extent to which workers are prepared to disclose. In turn, this can limit the depth of insight and learning that can occur as a result.
- Where primarily group supervision is offered, it may be helpful for services to have the flexibility or discretion to offer individual supervision sessions to staff on an as needs basis, for example for a limited number of sessions if things have been particularly difficult or stressful for a worker, if a worker is just so uncomfortable with group settings that it is simply not helpful to require them to attend, or for very senior workers, for whom it would be difficult to have their needs met in a group with less experienced workers.

Organisational considerations 8

8.1 Developing a supportive environment

It is important for services to consider what strategies might be needed to engender a culture of support for clinical supervision. Commonly in D&A services the values of workers in relation to the concept of clinical supervision are variable, as is their degree of support for it. In addition, workers have varied experiences of clinical supervision, often related to their professional background. For example:

- Psychologists and social workers have generally participated in clinical supervision from the outset of their training and tend to value it highly.
- There is less consistency in the understanding and experiences of nurses in relation to clinical supervision, and their training has often included a quite different type of supervision focused on competency development. Where nurses have not accessed clinical supervision (as defined in these Guidelines) they can be wary or suspicious of it.
- Workers who do not have tertiary or formal qualifications can have limited understanding of, or experience in, clinical supervision and can also be wary or suspicious.
- There are wide variations in the extent to which medical staff have participated in clinical supervision, and historically there can be a measure of resistance from some individual clinicians to participation in such activities.
- Across all professional groups there are workers who believe that they do not need clinical supervision, usually because they consider themselves to be sufficiently experienced. There are also workers who do not want to participate due to a fear of having to change, or of being exposed as inadequate.

The comments above are clearly generalised, and are not intended to reflect negatively on any professional group or individual. Rather they are highlighted because in being aware of such differences, D&A services can consider how they might best work with these factors in building a climate of support for their clinical supervision program, increase staffs' understanding about its purpose and benefits, and increase compliance in line with the service's expectations of staff participation.

How clinical supervision is marketed or introduced to staff can be critical to the success of its uptake. Line managers and clinical leaders can play an important role in building support, and it is likely that where people in such positions present a positive and encouraging attitude, this will have a constructive effect. Conversely in organisations where managers and clinical leaders are not supportive, and make their views known either overtly or covertly, this can have a negative impact on the climate of support for and participation in clinical supervision.

In particular it is considered important for managers and clinical leaders to:

- Provide staff with clear information about what supervision is and take the necessary time to introduce the concept, and allow for discussion of their queries, concerns or issues.
- Be clear about what clinical supervision isn't; make sure that staff understand that it is not a line management function, that it is not an opportunity simply to find fault with their work, and that it is not simply a mechanism for debriefing.
- Make sure that staff are provided with clear information about the boundaries of confidentiality that apply to supervision sessions.
- Highlight the benefits of supervision for staff, rather than simply focusing on its role in clinical quality. Staff should be made aware that it is a process put in place for their benefit and gain, for example to ensure they have an appropriate level of professional support for their work and to assist them in developing their clinical skills and expanding their experiences.
- Actively demonstrate their support for clinical supervision, for example by participating in their own clinical supervision, and through enabling staff to participate by arranging rostering to accommodate it, and assisting in their selection of clinical supervisors.

8.2 Recruitment and selection of supervisors

The success of clinical supervision is heavily dependent on having competent, appropriate and effective supervisors, and ensuring there are appropriate recruitment and selection processes in place for both internal and external supervisors is a key organisational consideration. There is a high level of constancy in the literature about appropriate criteria for the selection of supervisors. These are outlined below and are recommended as a basis for selection processes within D&A services. Clinical supervisors will ideally have:

- Relevant formal qualifications.
- Extensive clinical experience, specifically a breadth of counselling and/or therapy experience, particularly with complex clients and behavioural therapies. In general it is considered ideal for the supervisor to have more experience than the supervisee, although this is obviously not possible for some very senior staff, for whom peer supervision is appropriate.
- A clear understanding of the role and function of clinical supervision.
- A demonstrated history of continued professional development and supervision of their own clinical supervision practices.
- A demonstrated interest in and ability to enhance the skills and abilities of others, particularly to provide constructive feedback and to ensure a safe environment for disclosure and challenge.
- Held in high respect within their field or specialty.
- An understanding of and respect for the particular role of the supervisee.
- If providing group supervision, supervisors need demonstrated facilitation, group work and mediation skills.
- The ability to remain impartial and balanced in their views.
- An empathetic and non-judgemental approach.
- An intellectual interest in their professional arena.
- If providing supervision to Aboriginal and Torres Strait Islander workers, they must have demonstrated cultural awareness, and previous experience working with Aboriginal and Torres Strait Islander workers.

Selection processes for supervisors should be similar to those in place for recruitment to other positions, and in line with the organisation's recruitment policy, for example the development of a duty statement outlining the role and responsibilities, submission of formal, written applications, the convening of a selection panel to make decisions, and the requirement for referee checks. Where external clinical supervisors are contracted, they should also undergo a criminal record check.

8.3 The importance of policy, procedures and record keeping

Ideally, clinical supervision within D&A services should be governed by a written policy, and currently this is common practice. Staff and supervisors should be made aware of the policy and any accompanying procedures. In addition, a degree of record-keeping and documentation is recommended, some of which can be kept confidential.

Records which are not considered confidential, and which are commonly provided to managers include summary information from supervisors about numbers of attendees, session times and general, de-identified reports summarising the conduct of clinical supervision over a period of time.

A level of confidential record keeping is also expected in most D&A services, and recommended in the literature, for example records kept by both supervisors and supervisees relating to the goals and expectations, plans for achieving agreed goals, summaries of what has been undertaken in individual clinical supervision sessions, and reports arising from regular review about goals and achievements. (Examples at Appendices 6 and 7). All such records would remain confidential except in the circumstances outlined in section 6, in which case they may be required for the purposes of any investigation arising from breaches of code of conduct or clinical safety, or in the event of any other formal investigation related to a worker.

Whilst there is room for flexibility in terms of record keeping, local policies need to make clear their expectations and requirements.

8.4 Infrastructure and support for Clinical Supervision

Clinical supervision programs, like any other initiative, require a degree of organisational support and infrastructure if they are to be effective and efficient. Most D&A services have a policy that provides some governance and this is considered essential. However, there are additional factors to consider, outlined below:

- The need to locate responsibility for clinical supervision within an appropriate organisational portfolio. Given its stated purpose, the two obvious fits are workforce development and clinical quality, and ensuring that some overarching responsibility and leadership is provided through one of these portfolios is recommended.
- Consideration of a staff member with designated responsibility for coordinating the clinical supervision program. The roles of the key parties (managers, supervisors and supervisees) have been outlined earlier; however, there is also merit in the organisation designating responsibility for overall coordination and management of the clinical supervision program. This is not to suggest that a full-time position is required, but rather that a staff member with an appropriate related role (for example Coordinator of Quality, Workforce Development Manager) could also take on responsibility for clinical supervision.
- Establishing a clinical supervision advisory committee (or similar) with appropriate membership and specific terms of reference to oversight the policy and its implementation.
- Where an internal supervision model is used, establishing a network of supervisors, with a designated coordinator. The aims of the network could include ongoing training and development, support and debriefing.
- Embedding the organisational requirements about clinical supervision in relevant job descriptions. This is applicable to staff who are expected to access supervision, and to staff who provide internal clinical supervision.

8.5 Resourcing Clinical Supervision

Like any other activity or program, clinical supervision requires human and financial resourcing. Contributing resourcing factors include the time and effort required to provide appropriate infrastructure and coordination functions, to provide training, support and external clinical supervision for internal supervisors, staff time to participate, costs associated with travel to attend, and payment for the use of external supervisors. If the implementation of clinical supervision programs is to be an expectation across the board in D&A services then Directors and managers will need to take account of this in budget and business planning. It is beyond the scope of these Guidelines to suggest or recommend any strategies related to budget, suffice to highlight that it is an important organisational consideration.

8.6 Monitoring and evaluation

There has historically been a level of tension between the principle of confidentiality that applies to clinical supervision and the desire for organisations to have in place an appropriate level of monitoring and accountability for clinical supervision processes. The important distinction to highlight here is between performance management issues related to *individuals*, which need to be identified and addressed through other mechanisms, and mechanisms for quality assurance in relation to the overall clinical supervision *program*, which are appropriate and necessary.

Unless there are breaches of relevant codes of conduct, concerns for client or worker safety or breaches of duty of care (as outlined in section 6) the content of individual supervision sessions remains confidential, and issues related to the supervisee's clinical practice do not enter into the public domain of the organisation. However, the organisation does have a responsibility to have a level of reporting in place in relation to clinical supervision, and to have mechanisms in place to monitor and evaluate its effectiveness. For example it is appropriate for organisations to have information related to:

- The extent of uptake of supervision, specifically, which staff are attending supervision and how often.
- Where internal supervisors are utilised, which staff are active and their clinical supervision caseload.

- The extent of human and financial resources being utilised for the provision of clinical supervision.
- The satisfaction levels of staff in relation to the clinical supervision that is provided.
- Any areas of concern about the current clinical supervision program.
- The effectiveness of individual clinical supervisors.
- The impact and benefits of clinical supervision from the perspectives of staff and managers.
- Where internal supervisors are used, information about their participation in any required or recommended quality assurance processes, for example supervision of supervisors, attendance at supervision network meetings, and participation in ongoing training and development opportunities related to their supervisory role.

Some of the above information can be collected by ensuring a basic level of record keeping and reporting on the part of supervisors and managers, for example in relation to attendance and numbers, and it is suggested that such information be collected and reported as a matter of course. To assess satisfaction, impact and effectiveness, formal evaluation tools will need to be utilised. Some of the key issues to consider in evaluating clinical supervision are:

- The importance of having a degree of independence when seeking staff feedback about clinical supervision processes, for example having someone in a neutral role coordinate the process, analyse and report on results.
- The importance of getting feedback from supervisees and supervisors. Both viewpoints will provide useful information in relation to perceptions of the quality of clinical supervision sessions, satisfaction levels, if and how it has been helpful, the degree of fit between supervisor and supervisee, and ideas about strengthening the current processes.
- The need to ensure that supervisees can provide anonymous feedback, which will be particularly important where supervisors are internal.
- Being able to identify individual supervisors in any evaluation process so that constructive feedback can be provided, areas of development identified, and any serious concerns can be addressed directly with the individual supervisor.
- Ensuring that supervisors and supervisees are informed from the outset of any monitoring or evaluation processes that may be implemented, including the expectations of their participation in formal evaluation.

Some D&A services have agreed proformas for monitoring and evaluation purposes and there are samples at Appendices 8, 9, and 10.

8.7 Managing difficulties

Difficulties can and do arise within clinical supervision programs, and it is wise for local policies to clearly identify the intended processes for dealing with problems or conflict. Examples of issues that can arise are:

- A staff member is not happy with their clinical supervisor.
- There are problems with the mix of membership of a clinical supervision group.
- Managers have concerns about a particular supervisor.
- There are breaches of confidentiality of clinical supervision sessions.
- A staff member consistently doesn't attend their agreed clinical supervision.
- A staff member has been unable to resolve an issue with clinical supervision through their line manager.

Common principles for addressing these or similar issues are for the matter to be raised between the relevant parties in the first instance and attempts made to manage or resolve the issues. Where issues remain, it is generally recommended that they are taken to the line manager, or where appropriate, to a more senior staff member. Whilst this may seem an overly obvious approach, it is considered useful for local clinical supervision policies to highlight some of the common problems that may arise, and outline the expectations of how these will be managed so that all parties have a clear way forward. All AHSs have grievance procedures that should be followed when all other attempts at resolution have been unsuccessful.

A common concern for line managers can be the lack of information flow between clinical supervisors and managers about the performance of individual workers.

As a general rule, and for reasons outlined earlier related to the role, purpose and key characteristics of clinical supervision, it is recommended that services do not blur the boundaries between line management and clinical supervision, for example by managers approaching supervisors with concerns they have, or seeking comments or information about individual workers.

8.8 Issues for rural D&A services

There are particular issues in relation to implementing clinical supervision in rural D&A services. These include:

- Barriers associated with the provision of supervision to remote staff who were often isolated and therefore potentially in greater need of clinical supervision.
- The extent of time and travel required for staff to access face-to-face supervision.
- Difficulties in accessing appropriate supervisors. Internally, there may be insufficient professional distance between supervisees and supervisors. Externally there are often limitations or shortages in the number of private practitioners working in rural communities and there may not be appropriately skilled or senior staff available within the local community.

Rural D&A services need to consider alternative mechanisms to face-to-face clinical supervision such as telephone, email or videoconferencing, all of which have been utilised successfully for clinical supervision purposes. Studies in e-supervision have been undertaken and report both advantages and disadvantages, with the noted advantages being more relaxed communication styles, greater immediacy of responses, and greater mentoring capacity. Some of the noted challenges of electronic supervision are the need for increased time for planning supervisory sessions and the need for frequent and ongoing training for operating the required technology.[7]

7 Noreen Graf, Using email for clinical supervision in practicum: a qualitative analysis of email supervision, in Journal of Rehabilitation July-Sept 2002.

Useful resources and additional reading

9

This document provides guidance for D&A services in relation to the operation and management of clinical supervision programs, drawn from what is commonly considered sound practice in the literature, and within the NSW D&A field. It is not intended to be prescriptive, nor wholly comprehensive, and has been informed by a range of existing resources and previous work by other authors. This section provides a summary of additional sources of clinical supervision information and advice that D&A services will likely find valuable.

9.1 D&A specific resources

Three resources are worthy of particular note.

The first is the recently produced, and very comprehensive *Clinical Supervision Resource Kit for the Alcohol and Other Drugs Field*. Developed by the National Centre for Education and Training on Addiction (NCETA) at Flinders University, this kit is intended to build capacity of the D&A workforce, and includes the following components:

- An *Overview* booklet that provides an overview of all the materials contained in the Resource Kit, as well as a sample one-day training program for clinical supervisors.
- A comprehensive *Practical Guide* for the AOD field, which includes a review of the relevant literature and practical recommendations for establishing clinical supervision programs and conducting supervision sessions.
- A *Clinical Supervision Training Demonstration* on DVD which contains a 40 minute scripted demonstration of clinical supervision in four sessions, revealing the key process and content issues.
- A *Training Demonstration Booklet*, which is a supplement to the DVD and provides guidance about the DVD's use for training purposes.
- A *CD* containing PDF versions of all the materials contained within the kit, as well as a set of 75 PowerPoint training slides.

Further information about the kit can be found at the NCETA website www.nceta.flinders.edu.au/

The second is the *Workforce Development Resource Kit: A Guide to Workforce Development for Alcohol and Other Drugs Agencies*. Produced by the Network of Alcohol and Other Drugs Agencies (NADA) this resource includes useful information about implementing clinical supervision programs in section 4.6, and includes relevant case studies. The Kit can be found on the NADA website www.nada.org.au/training/WorkforceDevelopment_ResourceKit.pdf

Finally, there is the considerable work that was conducted by *Access Macquarie Ltd* as part of their related project to develop and deliver a training package in clinical supervision for NSW Health D&A services. This work includes:

- The training package *Clinical Supervision Training for D&A Professionals – Participant Handbook*, developed by Daphne Hewson, Access Macquarie Ltd, November 2005, for the CDA, NSW Health.
- *Clinical Supervision training package, Final Report to the CDA*, Daphne Hewson, Access Macquarie Ltd, November 2005. (Including appendices on Aboriginal Consultations, Interviews and the Email Survey.)

9.2 Useful Clinical Supervision references

In addition to the above resources, many other articles and references were reviewed, and the following is a summary of those that were considered particularly helpful or relevant in the development of the Guidelines.

- Butterworth and Woods, Clinical Governance and Clinical Supervision; working together to ensure safe and accountable practice; A Briefing Paper. The School of Nursing, Midwifery and Health Visiting, University of Manchester 1999.
- Kavanagh et al, Achieving effective supervision. Drug and Alcohol Review 2002.
- The Development of models of nursing supervision in the UK, and other documents and information contained on the website of Steve Cottrell and Georgina Smith at www.clinical-supervision.com

- Chris Shanley, Clinical Supervision – an untapped resource for the alcohol and other drug field, Centre for Education and Information on Drugs and Alcohol, NSW (CEIDA).
- Butterworth et al, First Steps Towards Evaluating Clinical Supervision in Nursing and Health Visiting. Journal of Clinical Nursing Vol 5(2) March 1996.
- Ian Clift and Janet Perks, Clinical Supervision Policy and Framework, The Cambridgeshire and Peterborough Mental Health Partnership NHS Trust, 2004.
- JE Mills, KL Franciss & A Bonner, Mentoring, clinical supervision and preceptoring: Clarifying the conceptual definitions for Australian Rural Nurses. A review of the literature, Rural and Remote Health, the International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, 2005.
- Noreen Graf, Using email for clinical supervision in practicum: a qualitative analysis of email supervision, Journal of Rehabilitation July-Sept 2002.
- Winstanley J and White E (2002) Clinical Supervision: Models, Measures and Best Practice. Australia and New Zealand College of Mental Health Nurses Inc, Sydney.

Appendix 1.
Membership of the advisory group

Bob Batey
Director
Drug and Alcohol
Hunter and New England Area Health Service
Clinical Advisor
Centre for Drug and Alcohol
NSW Health

Tonina Harvey
Director
Drug and Alcohol Services
Northern Sydney and Central Coast Area Health Service
Co-Chair of Nursing Advisory Committee

Steve Childs
Assistant Director
Counselling and Psychological Services
Northern Sydney and Central Coast Area Health Service
Co-Chair of Allied Health Workers Advisory Committee

Thiagarajan Sitharthan
Director
Clinical Programs
Drug and Alcohol Services
Sydney West Area Health Service

James Pitts
Chief Executive Officer
Odyssey House

Nick Miles
Clinical Nurse Consultant
Drug and Alcohol Services
Northern Sydney and Central Coast Area Health Service

Dr James Guinan
Senior Clinical Psychologist
Area Manager Community Drug and Alcohol Programs
Northern Sydney Health

Debbie Kaplan
Centre For Drug and Alcohol
NSW Health

Trish O'Riordan
Centre For Drug and Alcohol

Doug Smyth
Centre For Drug and Alcohol

Appendix 2. Codes of conduct and professional practice

Attention to issues related to codes of conduct and ethical behaviour operate on two separate levels. Firstly there is a need for supervisors to ensure that their own clinical supervision practices are carried out within the parameters of relevant codes of conduct; and secondly there is a need for supervisors to be cognisant of the codes of conduct and ethical practice that apply to the staff they are supervising.

In relation to the first of these, namely the clinical supervision practices of supervisors, the following highlights the key issues that supervisors should be aware of:

- The potential for vicarious liability, whereby a supervisor can be held liable for the conduct of the supervisee, especially if the supervisee is not a fully licensed professional.
- The need to ensure that the limits of the confidentiality of supervision are clearly stated at the outset. Should it become necessary to disclose, only information that is necessary and sufficient to address the pertinent issue should be disclosed.
- Supervisors should not practice outside their area of competence or overextend themselves and they should ensure that supervisees do not practice outside their area of competence or overextend themselves.
- Supervisors have a duty to warn and to protect, and are responsible for ensuring that clients at risk (eg suicide risk) are protected and, when legally warranted, that others are warned if they are at risk from a client.
- Supervisors are responsible for ensuring that they and those they supervise conduct themselves within the ethical guidelines and codes of conduct of their profession, and their employing organisation. Particular attention should be paid to gaining relevant informed consent (eg from clinicians for degree of self-disclosure in supervision; from clients to receiving treatment from and intern/trainee).
- Supervisors are responsible for ensuring that neither they nor those they supervise have dual relationships (eg can't be supervisor and therapist; no sexual relationships between supervisor and counsellors or counsellors and clients, etc). The dual relationship of Line-Manager and Supervisor is not ideal; and if it becomes necessary, extra care should be taken to create safe boundaries between the two roles.
- Supervisors are responsible for ensuring that the supervisee's rights are addressed by providing a clear statement of the requirements of clinical supervision, and specific information about what will be evaluated, through the supervisory process and how.

In addition, the Australian Psychological Society has produced an ethical guidelines paper on clinical supervision. Whilst the paper is only available online to members, most D&A services will have staff who are members and will have access. The paper is entitled Australian Psychological Society Ethical Guidelines: Guidelines on Supervision, July 2003 and can be found at www.psychology.org.au/

Supervisors also need to ensure that they are familiar with the relevant ethical guidelines and codes of conduct that apply to staff they are supervising. A number of codes are likely to apply within D&A services as follows:

- Area Health Service Codes of Conduct.
- NSW Medical Board Code of Professional Conduct.
- Code of Ethics for Nurses in Australia (Developed under the auspices of Australian Nursing and Midwifery Council, Royal College of Nursing, Australia and the Australian Nursing Federation).
- Code of Professional Conduct for Nurses in Australia (Australian Nursing and Midwifery Council).
- Australian Association of Social Workers Code of Ethics.
- NSW Psychologists Registration Board Code of Professional Conduct.
- The Australian Psychological Society Code of Ethics.
- Australian Counselling Association Code of Conduct.

Whilst a brief summary of information contained within the above codes is outlined below, it is strongly recommended that supervisors access the relevant codes in full to ensure they are clear about the full extent of ethical and professional parameters that apply.

In circumstances where a supervisor is unclear about the application or interpretation of a particular code, they are encouraged to seek advice from a senior staff member from within the same profession as the supervisee.

D&A Services Codes of Conduct

All Area Health Services have codes of conduct in place for staff and D&A services need to ensure that staff and supervisors are provided with copies of the relevant organisational policy documents. Notwithstanding the need for all parties to have a sound understanding of the particular ethical and professional guidelines, commonly AHS Codes of Conduct refer to the need for staff to comply as follows:

- To be aware of and avoid potential situations of conflict of interest, for example whereby they could be influenced or perceived to be influenced by a personal interest when carrying out their public duty.
- Staff must not accept gifts or benefits from clients which could in any way influence, or appear to influence, their official capacity.
- Staff must not submit or accept bribes or inducements from individuals or organisations.
- The requirement for staff to behave honestly and with integrity in the execution of their duties.
- Staff must not develop inappropriate personal relationships with clients, including social, sexual or financial relationships.
- Staff must not harass, bully or discriminate against others, including colleagues and clients.
- Staff must not use official resources for non-official purposes.
- Staff must not engage in corrupt conduct, as defined in sections 8 and 9 of the *Independent Commission Against Corruption Act (1988)*, including in relation to official misconduct, bribery and blackmail, unauthorised use of confidential information, fraud and theft.

NSW Medical Board Code of Professional Conduct

There are four standards outlined in this code as follows:

Standard 1

You must possess and apply adequate knowledge and skill in the practice of medicine.

Standard 2

You must observe professional and ethical obligations. These include:

- Education, teaching and training responsibilities.
- Providing honest assessment of the performance of colleagues.
- Putting patients first while putting aside your own personal views.
- Maintaining trust with patients through your interaction with patients.
- Arranging appropriate alternative treatment when the doctor/patient relationship deteriorates.
- Disclosure of adverse events to appropriate authorities.
- Responding appropriately to situations in which a complaint is made about your treatment or where treatment is unsuccessful.
- Co-operating fully with the investigating authorities such as the HCCC and the NSW Medical Board in respect of adverse events.
- Dealing appropriately with the next of kin of deceased patients.
- Ensuring your professional position is not abused or compromised through improper financial or personal dealings with patients.
- Ensuring that your own health or that of another practitioner does not put patients at risk.
- Ensuring other practitioners do not place patients at risk through their health, conduct or performance.
- Providing factual information about your services.

Standard 3

You must ensure that you enjoy a good relationship with all colleagues in health care teams:

- Through treating colleagues with respect regardless of your personal views.
- By working constructively with health care teams.
- By ensuring patient treatment is covered during your own absence or unavailability.
- Ensuring that a patient's care is co-ordinated.
- Ensuring appropriate delegation and referral of care of a patient.

Standard 4

You must display probity in your professional practice in respect of:

- Financial and commercial dealings.
- Financial interests in hospitals, nursing homes and other medical organisations.
- Not accepting gifts or other inducements.
- Not entering into financial agreements with patients which may compromise the therapeutic relationship.
- Ensuring that any documents signed by you are not false or misleading.
- Ensuring that research in which you are engaged is conducted ethically and according to protocol and that you report fraud or misconduct in research to the appropriate authority.

The full document can be found at:
www.medeserv.com.au/nswmb/publications/Code_of_Conduct.cfm

Code of Ethics for Nurses in Australia

The Code of Ethics includes the following six key value statements. Nurses respect individuals' needs, values, culture and vulnerability in the provision of nursing care.

- Nurses accept the rights of individuals to make informed choices in relation to their care.
- Nurses promote and uphold the provision of quality nursing care for all people.
- Nurses hold in confidence any information obtained in a professional capacity, use professional judgement where there is a need to share information for the therapeutic benefit and safety of a person and ensure that privacy is safeguarded.
- Nurses fulfil the accountability and responsibility inherent in their roles.
- Nurses value environmental ethics and a social, economic and ecologically sustainable environment that promotes health and well-being.

The full document can be found at:
www.anf.org.au/pdf_general/code_of_ethics.pdf

Code of Professional Conduct for Nurses in Australia

The purpose of the Code of Professional Conduct for Nurses in Australia is to:

- Set an expected national standard of conduct for the nursing profession.
- Inform the community of the standards for professional conduct of nurses in Australia.
- Provide consumer, regulatory, employing and professional bodies with a basis for decisions regarding standards of professional conduct.

Under the code of professional conduct a nurse must:

- Practise in a safe and competent manner.
- Practise in accordance with the agreed standards of the profession.
- Not bring discredit upon the reputation of the nursing profession.
- Practise in accordance with laws relevant to the nurse's area of practice.
- Respect the dignity, culture, values and beliefs of an individual and any significant other person.
- Support the health, well being and informed decision-making of an individual.
- Promote and preserve the trust that is inherent in the privileged relationship between a nurse and an individual, and respect both the person and property of that individual.
- Treat personal information obtained in a professional capacity as confidential.
- Refrain from engaging in exploitation, misinformation and misrepresentation in regard to health care products and nursing services.

The full document can be found at:
www.nursesreg.nsw.gov.au/ANMCProfessionalConduct.pdf

Australian Association of Social Workers Code of Ethics 1999

The purpose of the Code is to:

- Identify the values and principles which underpin ethical social work practice.
- Provide a guide and standard for ethical social work conduct and accountable service.
- Provide a foundation for ethical reflection and decision-making.
- Guide social workers when determining what demands they may legitimately make on their employers, colleagues and the AASW.
- Provide clarification of social workers' actions in the context of industrial or legal disputes.
- Act as a basis for investigation and adjudication of formal complaints about unethical conduct.

The full document can be found at:
www.aasw.asn.au/adobe/about/AASW_Code_of_Ethics-2004.pdf

NSW Psychologists Registration Board Code of Professional Conduct

The Code of Professional Conduct provides principles and guidelines for observation byregistered psychologists in their professional practice, and that guide the interpretations relevant to Part 4 of the *Psychologists Act 2001* related to complaints and disciplinary proceedings). Under the code psychologists will:

- Demonstrate continuing competence in their practice of psychology that includes adequate knowledge, skill, judgment and care.
- Aim to maximise benefit and do no harm in their practice of psychology.
- Respect the dignity and welfare of individuals and groups with whom they have professional contact.
- Act ethically and properly and will promote accuracy, fairness and honesty in their practice of psychology.

The full document can be found at:
www.psychreg.health.nsw.gov.au/hprb/psych_web/pdf/codeofconduct.pdf

The Australian Psychological Society Code of Ethics

The code outlines principles of ethics and professional practice for members of the Society which aim to safeguard the welfare of consumers of psychological services and the integrity of the profession. Its general principles state that:

- Members remain personally responsible for the professional decisions they make.
- Members shall bring and maintain appropriate skills and learning in their areas of professional practice.
- The welfare of clients and the public, and the integrity of the profession shall take precedence over a member's self interest and over the interests of the member's employer and colleagues.

The full document can be found at:
www.psychology.org.au/aps/ethics/code_of_ethics.pdf

Australian Counselling Association Code of Conduct

This code is intended to provide standards of professional conduct that can be applied by the ACA and by other bodies that chose to adopt them in Australia. Under the code, members will:

- Offer a non judgmental professional service, free from discrimination, honouring the individuality of the client.
- Establish the helping relationship in order to maintain the integrity and empowerment of the client without offering advice.
- Be committed to ongoing personal and professional development.
- Ensure client understanding of the purpose, process and boundaries of the counseling relationship.
- Offer a promise of confidentiality and explain the limits of duty of care.
- For the purpose of advocacy, receive written permission from the client before divulging any information or contacting other parties.
- Endeavor to make suitable referral where competent service can not be provided.
- Undertake regular supervision and debriefing to develop skills, monitor performance and sustain professional accountability.

- Be responsive to the needs of peers and provide a supportive environment for their professional development.
- Not act as or practice legal council on behalf of or to a client when practicing as a counselor or act as an agent for a client.
- Not initiate, develop or pursue a relationship be it sexual or nonsexual with past or current clients, within 2 years of the last counseling session.
- Be responsible for your own updating and continued knowledge of theories, ethics and practices through journals, the association and other relevant bodies.
- Be committed to the above code of ethics and recognise that procedures for withdrawal of membership will be implemented for breaches.

Full document can be found at:
www.theaca.net.au/docs/code_conduct.pdf

Appendix 3.
Clinical Supervision contract (example)

This proforma is an example of the kind of contract or agreement used between supervisor and supervisee in relation to the arrangements and processes for clinical supervision sessions. It is a sample only and D&A services need to ensure contracts meet their specific needs.

This agreement covers the clinical supervision arrangements between:

_____

(Supervisee), and

_____

(Supervisor)

Structure of sessions

We agree the structure of clinical supervision sessions will be as follows:

Frequency _____

Duration _____

Time _____

Location _____

Goals of clinical supervision for the agreed contract period:

_____

_____

_____

_____

_____

Agreed strategies and methods of achieving these goals:

_____

_____

_____

_____

_____

Agreed records to be kept in relation to clinical supervision:

_____

_____

_____

_____

_____

We have read the D&A Service Clinical Supervision Policy and agree to operate in compliance with it.

Supervisors signature _____

Date _____/_____/_____

Supervisees signature _____

Date _____/_____/_____

Appendix 4. External Clinical Supervisor contract 1 (example)

This proforma is one of two examples of the kind of contract or agreement used between the D&A service and an external clinical supervisor. It is a sample only and D&A services need to ensure contracts meet their specific needs.

Parties to the contract

This contract is between:

_____

(D&A Service), and

_____

(external Clinical Supervisor)

The agreed terms of the contract are:

Commencing date _____/_____/_____

Completion date _____/_____/_____

Renewal of Contract is subject to performance review and availability of funds.

Services and remuneration

The number of hours per month will be approximately

_____ Variations to be approved by Area Manager, Drug & Alcohol, as required.

Remuneration will be at Australian Psychological Society (APS) current standard rate currently _____ per hour plus GST.

Clinical supervision services will be provided in accordance with the D&A Service Clinical Supervision Policy and as per the attached schedule.

Insurance

The Provider shall insure themselves and keep himself/herself insured during the period of the Contract with an insurance office approved by the Health Service to the full extent against his liability to his/her employees employed in the performance of the Contract, under the laws relating to Workers' Compensation. The Contractor shall also on demand produce to the Health Service evidence of renewal of such insurance.

The Provider shall also insure themselves and keep himself/herself insured during the period of the Contract for public liability and Professional Indemnity insurance in the amounts as follows:

$_____ Public liability insurance

$_____ Professional indemnity insurance

The Provider will supply the following information in relation to insurance:

- Name of insurance companies with whom cover is affected.
- Policy number of the Policies.
- The expiry date or currency of the policies.

Termination of Contract

The Contract shall be terminated:

a. Upon the expiry of the period for which it was made or on such earlier date and may be agreed between the Clinical Supervisor and the Health Service.
b. By one months' notice in writing given by either the Clinical Supervisor or the Health Service.
c. If the Clinical Supervisor ceases to be registered as a Psychologist in NSW.
d. If the Clinical Supervisor becomes permanently mentally or physically incapable of rendering services under the contract.
e. If the Clinical Supervisor commits serious and/or willful misconduct; or
f. If the Clinical Supervisor appointment is terminated by operation of any Act or Regulation.

On the termination of a Contract, any amount due and payable to the Clinical Supervisor pursuant to the Contract shall be paid at the time of such termination or as soon thereafter as reasonably practicable.

Dispute Resolution Procedure

In the event that the Clinical Supervisor or Health Service is dissatisfied with any aspect of the operation of the Contract, the Clinical Supervisor or Health Service may give the other party notice in writing, identifying the matter or matters the subject of dispute. As soon as practicable after the giving of notice, Health Service staff and the Clinical Supervisor, who may be accompanied by an observer of his/her choice, shall meet to discuss the dispute and attempt to resolve it by a mutually agreed method.

Appendix 5. External Clinical Supervisor contract 2 (example)

This proforma is one of two examples of the kind of contract or agreement used between the D&A service and an external clinical supervisor. It is a sample only and D&A services need to ensure contracts meet their specific needs.

This contract is for a period of _____ months,

starting _____/_____/_____

Payment for clinical supervision services provided will be

$_____ per hour.

Supervision sessions contracted will be _____ hours per month.

As part of my role as an external supervisor, I agree to:

- Provide supervision, which is consistent with the services' aims and objectives.
- Consult with supervisee(s) in order to prepare a supervision contract. The supervision contract includes negotiated goals for a specified supervision period, strategies and methods to be used for achieving those goals, an outline of the structure and process of supervision, and a review date.
- Consent to annual internal staff satisfaction surveys.
- Maintain an accurate log of supervision sessions in accordance with plans agreed to with supervisees, which include the date and duration of each session. This is submitted annually to the line manager.
- Provide documentation on past professional experience and professional qualifications to the service manager.
- Continue my own professional development and supervision.
- Provide the Director of Drug and Alcohol Services (or delegate) with access to the supervision log when requested.
- Address any difficulties arising from the supervision relationship in accordance with the supervision guidelines within Drug and Alcohol Services.
- Ensure appropriate client and supervisee confidentiality
- Inform management and appropriate professional bodies where there is serious concerns about the client/patient health and safety due to the health status of the supervisee or non-adherence to professional codes of ethics and the Service's code of conduct
- Undergo a criminal record check.

I have read and understand the terms of this contract and the supervision guidelines for the Drug and Alcohol Service.

Signed _____

Date _____/_____/_____

Date for Review _____/_____/_____

Appendix 6. Record of Clinical Supervision session (example)

This is a sample of the kind of record that can be kept by individual **supervisees** following each clinical supervision session.

Date _____/_____/_____

Name of Supervisor_____

Name of Supervisee _____

What was the contract for the session?

_____

_____

_____

_____

_____

_____

Key issues identified during the session?

_____

_____

_____

_____

_____

_____

Action taken:

_____

_____

_____

_____

_____

What was learnt?

_____

_____

_____

_____

_____

_____

What will I do differently in the future?

_____

_____

_____

_____

_____

_____

Further agreements:

_____

_____

_____

_____

Comments:

_____

_____

_____

_____

Appendix 7. Record of Clinical Supervision session (example)

This is a sample of the kind of record that can be kept by **supervisors** following each clinical supervision session.

Date _____/_____/_____

Supervisor _____

Supervisee _____

What was the contract for the session?

_____

_____

_____

_____

_____

_____

Key issues identified during the session:

_____

_____

_____

_____

_____

_____

Action taken:

_____

_____

_____

_____

_____

_____

What will be done differently and by whom?

_____

_____

_____

_____

_____

_____

Checklist:

- ☐ Issues identified
- ☐ Ethical practice/compliance with codes of conduct
- ☐ Increased learning
- ☐ Objectives met

Notes and evaluation:

_____

_____

_____

_____

_____

_____

Plans for next supervision session:

_____

_____

_____

_____

_____

Appendix 8.
Annual evaluation form (example)

The following is an example of an annual evaluation form used by an external clinical supervisor to gather information from supervisees. **End of year clinical supervision evaluation.**

The following questionnaire has been designed to evaluate the clinical supervision sessions you have been receiving over the past year.

All responses are ANONYMOUS. Feel free to add any additional comments. Your responses will be provided to the Manager of your service for consideration for future clinical supervision in 2005.

How helpful has been clinical supervision been?

0 1 2 3 4 5 6 7 8 9 10

Not helpful at all Very helpful

What have been the most helpful aspects of clinical supervision?

_____

_____

_____

_____

_____

_____

What have been the least helpful aspects of clinical supervision?

_____

_____

_____

_____

_____

_____

How has clinical supervision influenced your work with drug and alcohol clients?

_____

_____

_____

_____

_____

_____

Has clinical supervision improved your understanding in working with drug and alcohol clients?

Great deal A little Not at all

Has clinical supervision improved the way you work therapeutically with drug and alcohol clients?

Great deal A little Not at all

Tick the areas you think your knowledge and skills have improved in:

- ☐ Assessment
- ☐ Understanding the clients concerns
- ☐ Interviewing skills
- ☐ Dual diagnosis
- ☐ Intervention skills
- ☐ Problem solving
- ☐ Team issues
- ☐ Other areas *(please state)* _____

_____

Appendix 8. Annual evaluation form (example)

What recommendations do you have to improve clinical supervision in the future?

_____

_____

_____

_____

_____

_____

Other comments:

_____

_____

_____

_____

_____

_____

Many thanks for completing this form.

Acknowledgement for this evaluation format to Christine Senediak

Appendix 9. Annual report from Clinical Supervisors (example)

The following is an example of an annual report provided by clinical supervisors to service managers. Note whilst there is no detailed information about the content of clinical supervision sessions, there is summary information related to compliance with the policy, and ethical practice.

CONFIDENTIAL

Annual Report

_____

(Supervisee's name)

has attended clinical supervision sessions with me

_____

(Supervisor's name)

on _____ occasions from

_____/_____/_____to_____/_____/_____.

Both supervisor and supervisee have signed records of these sessions.

The general goals of supervision as detailed in the Clinical Supervision Policy and the specific goals of the contracts agreed to during the period under review are designed to promote best practice. In my opinion, the supervisee is working towards these supervision goals.

☐ Yes ☐ No

Comments:

_____

_____

_____

_____

_____

_____

From discussion during supervision it would appear that the supervisee is performing according to the service Code of Conduct and in line with appropriate Professional Codes of Ethics for the discipline.

☐ Yes ☐ No

Comments:

_____

_____

_____

_____

_____

_____

Supervisors signature _____

Date _____/_____/_____

Supervisees signature _____

Date _____/_____/_____

cc Manager

Appendix 10. Clinical Supervision evaluation format (example)

The following supervision questionnaire was developed by Ladany, Hill and Nutt (1966) as measure of supervisee perceptions of the quality and outcomes of supervision. The score is the sum of the items.

1. How would you rate the quality of the supervision you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of supervision you wanted?

1	2	3	4
No definitely not	No not really	Yes generally	Yes definitely

3. To what extent has this supervision fit your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of supervision, would you recommend this supervisor to him or her?

1	2	3	4
No definitely not	No I don't think so	Yes I think so	Yes definitely

5. How satisfied are you with the amount of supervision you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Has the supervision you received helped you to deal more effectively in your role as a counselor or therapist?

4	3	2	1
Yes definitely	Yes generally	No not really	No definitely

7. In an overall, general sense, how satisfied are you with the supervision you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek supervision again, would you come back to this supervisor?

1	2	3	4
No definitely not	No I don't think so	Yes I think so	Yes definitely

SHPN (D&A) 060037